

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

H. ADMINISTRATIVE POLICIES

1. Provider Appeal Procedure

A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the DSHS (Medical Assistance Administration) except that no administrative appeals may be filed challenging the method described herein. The grounds for rate adjustments include, but are not limited to, errors or omissions in the data used to establish rates, changes in capital costs due to licensing or certification requirements, and peer group change recommended by the Washington State Department of Health.

Additional documentation, as specified by DSHS, may be required in order to complete the appeal review. DSHS (Medical Assistance Administration) may have an audit and/or desk review conducted if necessary to complete the appeal review.

A hospital may appeal its rates by submitting a written notice of appeal to the Rate Analysis Section, Medical Assistance Administration (MAA). Unless the written rate notification specifies otherwise, a hospital rate appeal requesting retroactive rate adjustments must be filed within sixty days after being notified of an action or determination the hospital wishes to challenge. The notification date of an action or determination is the date of the written rate notification letter. A hospital rate adjustment appeal, filed after the sixty-day period described in this subsection shall not be considered for retroactive adjustments.

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When an appeal is made, all aspects of this rate may be reviewed by DSHS. Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal filed within 60 days after the written rate notification letter that the hospital is challenging shall be effective retroactively to the effective date of the rate change as specified in the notification letter. Increases in rates resulting from a rate appeal filed after the 60 day period or exception period, shall be effective the date the appeal is filed with DSHS. Appeals resulting in rate decreases shall be effective on the date specified in the appeal decision notification.

A hospital may request a Dispute Conference to appeal an administrative review decision. The conference will be conducted by the MAA's Assistant Secretary or designee. The hospital must submit a request for a conference within 30 days of receipt of the administrative review decision. The Dispute Conference decision is the state agency's final decision regarding rate appeals.

2. Uniform Cost Reporting Requirements

Hospitals are required to complete and submit a copy of their annual Medicare cost reports (HCFA 2552), including Medicaid related data, to the MAA. In addition, hospitals are required to submit other financial information as required by the MAA to establish rates.

3. Financial Audit Requirements

The MAA will have cost report data used for rate setting periodically audited. In addition, hospital billings and other financial and statistical records will be periodically audited.

4. Rebasing & Recalibration

DSHS will rebase the Medicaid payment system on a periodic basis using each hospital's cost report for its fiscal year ending during the base year selected for the rebasing.

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Chapter 246-453 WAC
HOSPITAL CHARITY CARE

Last Update: 6/1/94

WAC

246-453-001	Purpose.
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246-453-080	Reporting requirements.
246-453-090	Penalties for violation.

DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

246-453-085 Charity care measurement. [Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-453-085, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 70.39 RCW. 85-01-007 (Order 84-07, Resolution No. 84-07), § 261-14-050, filed 12/7/84.] Repealed by 91-05-048 (Order 142), filed 2/14/91, effective 3/17/91. Statutory Authority: RCW 70.170.060.

WAC 246-453-001 Purpose. This chapter is adopted by the Washington state department of health to implement the provisions of chapter 70.170 RCW. These sections relate to hospital policies for charity care, bad debt and emergency medical care, including admission practices, the compilation and measurement of the level of charity care services provided by each hospital, and penalties for violation of these provisions.

[Statutory Authority: Chapters 43.070 [43.70] and 70.170 RCW. 94-12-089, § 246-453-001, filed 6/1/94, effective 7/2/94. Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-001, filed 2/14/91, effective 3/17/91. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-453-001, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 70.39 RCW. 85-01-007 (Order 84-07, Resolution No. 84-07), § 261-14-010, filed 12/7/84.]

WAC 246-453-010 Definitions. As used in this chapter, unless the context requires otherwise,

(1) "Department" means the Washington state department of health created by chapter 43.70 RCW;

(2) "Hospital" means any health care institution which is required to qualify for a license under RCW 70.41.020(2); or as a psychiatric hospital under chapter 71.12 RCW;

(3) "Manual" means the *Washington State Department of Health Accounting and Reporting Manual for Hospitals*, adopted under WAC 246-454-020;

(4) "Indigent persons" means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor;

(5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section;

(6) "Bad debts" means uncollectible amounts, excluding contractual adjustments, arising from failure to pay by patients whose care has not been classified as charity care;

(7) "Appropriate hospital-based medical services" means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all;

(8) "Medical staff" means physicians, dentists, nurses, and other professional individuals who have admitting privileges to the hospital, and may also participate as members of the medical staff committees, serve as officers of the medical staff, and serve as directors or chiefs of hospital departments;

(9) "Third-party coverage" and "third-party sponsorship" means an obligation on the part of an insurance company or governmental program which contracts with hospitals and patients to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others which have resulted in the medical condition for which the patient has received hospital services;

(10) "Unusually costly or prolonged treatment" means those services or combinations of services which exceed two standard deviations above the average charge, and/or three standard deviations above the average length of stay; as determined by the department's discharge data base;

(11) "Emergency care or emergency services" means services provided for care related to an emergency medical or mental condition;

(12) "Emergency department" and "emergency room" means that portion of the hospital facility organized for the purpose of providing emergency care or emergency services;

(13) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment of bodily functions;

(c) Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions the term shall mean:

(d) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(e) That transfer may pose a threat to the health or safety of the woman or the unborn child;

(14) "Responsible party" means that individual who is responsible for the payment of any hospital charges which are not subject to third-party sponsorship;

(15) "Limited medical resources" means the nonavailability of services or medical expertise which are required or are expected to be required for the appropriate diagnosis, treatment, or

stabilization per federal requirements of an individual's medical or mental situation;

(16) "Publicly available" means posted or prominently displayed within public areas of the hospital, and provided to the individual in writing and explained, at the time that the hospital requests information from the responsible party with regard to the availability of any third-party coverage, in any language spoken by more than ten percent of the population in the hospital's service area, and interpreted for other non-English speaking or limited-English speaking or other patients who can not read or understand the writing and explanation;

(17) "Income" means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual;

(18) "Family" means a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family;

(19) "Initial determination of sponsorship status" means an indication, pending verification, that the services provided by the hospital may or may not be covered by third party sponsorship, or an indication from the responsible party, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for charity care; and

(20) "Final determination of sponsorship status" means the verification of third party coverage or lack of third party coverage, as evidenced by payment received from the third party sponsor or denial of payment by the alleged third party sponsor, and verification of the responsible party's qualification for classification as an indigent person, subsequent to the completion of any appeals to which the responsible party may be entitled and which on their merits have a reasonable chance of achieving third-party sponsorship in full or in part.

[Statutory Authority: Chapters 43.070 [43.70] and 70.170 RCW. 94-12-089, § 246-453-010, filed 6/1/94, effective 7/2/94. Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-010, filed 2/14/91, effective 3/17/91. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-453-010, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 70.39 RCW. 85-01-007 (Order 84-07, Resolution No. 84-07), § 261-14-020, filed 12/7/84.]

WAC 246-453-020 Uniform procedures for the identification of indigent persons. For the purpose of identifying those patients that will be classified as indigent persons, all hospitals shall adopt and implement the following procedures:

(1) The initiation of collection efforts directed at the responsible party shall be precluded pending an initial determination of sponsorship status, provided that the responsible party is cooperative with the hospital's efforts to reach an initial determination of sponsorship status;

(a) Collection efforts shall include any demand for payment or transmission of account documents or information which is not clearly identified as being intended solely for the purpose of transmitting information to the responsible party;

(b) The initial determination of sponsorship status shall be completed at the time of admission or as soon as possible following the initiation of services to the patient;

(c) If the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, as described in WAC 246-453-040, collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the hospital's reasonable efforts to reach a final determination of sponsorship status;

(d) During the pendency of the initial determination of sponsorship status and/or the final determination of the applicability of indigent person criteria, hospitals may pursue reimbursement from any third-party coverage that may be identified to the hospital;

(e) The requirements of this subsection shall not apply to clinics operated by disproportionate share hospitals, as defined and identified by the department of social and health services, medical assistance services, provided that patients are advised of the availability of charity care at the time that services are provided and when presented with a request for payment.

(2) Notice shall be made publicly available that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.

(3) Any responsible party who has been initially determined to meet the criteria identified within WAC 246-453-040 shall be provided with-at least fourteen calendar days or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present documentation as described within WAC 246-453-030 prior to receiving a final determination of sponsorship status.

(4) Hospitals must make every reasonable effort to determine the existence or nonexistence of third-party sponsorship that might cover in full or in part the charges for services provided to each patient.

(5) Hospitals may require potential indigent persons to use an application process attesting to the accuracy of the information provided to the hospital for purposes of determining the person's qualification for charity care sponsorship. Hospitals may not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures. The failure of a responsible party to reasonably complete appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.

(6) Hospitals may not require deposits from those responsible parties meeting the criteria identified within WAC 246-453-040 (1) or (2), as indicated through an initial determination of sponsorship status.

(7) Hospitals must notify persons applying for charity care sponsorship of their final determination of sponsorship status within fourteen calendar days of receiving information in accordance with WAC 246-453-030; such notification must include a

determination of the amount for which the responsible party will be held financially accountable.

(8) In the event that the hospital denies the responsible party's application for charity care sponsorship, the hospital must notify the responsible party of the denial and the basis for that denial.

(9) All responsible parties denied charity care sponsorship under WAC 246-453-040 (1) or (2) shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the hospital's chief financial officer or equivalent.

(a) Responsible parties shall be notified that they have thirty calendar days within which to request an appeal of the final determination of sponsorship status. Within the first fourteen days of this period, the hospital may not refer the account at issue to an external collection agency. After the fourteen day period, if no appeal has been filed, the hospital may initiate collection activities.

(b) If the hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized.

(c) In the event that the hospital's final decision upon appeal affirms the previous denial of charity care designation under the criteria described in WAC 246-453-040 (1) or (2), the responsible party and the department of health shall be notified in writing of the decision and the basis for the decision, and the department of health shall be provided with copies of documentation upon which the decision was based.

(d) The department will review the instances of denials of charity care. In the event of an inappropriate denial of charity care, the department may seek penalties as provided in RCW 70.170.070.

(10) Hospitals should make every reasonable effort to reach initial and final determinations of charity care designation in a timely manner; however, hospitals shall make those designations at any time upon learning of facts or receiving documentation, as described in WAC 246-453-030, indicating that the responsible party's income is equal to or below two hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of charity care status shall have no bearing on the identification of charity care deductions from revenue as distinct from bad debts.

(11) In the event that a responsible party pays a portion or all of the charges related to appropriate hospital-based medical care services, and is subsequently found to have met the charity care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the charity care designation.

[Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-020, filed 2/14/91, effective 3/17/91.]

WAC 246-453-030 Data requirements for the identification of indigent persons. (1) For the purpose of reaching an initial determination of sponsorship status, hospitals shall rely upon

information provided orally by the responsible party. The hospital may require the responsible party to sign a statement attesting to the accuracy of the information provided to the hospital for purposes of the initial determination of sponsorship status.

(2) Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:

- (a) A "W-2" withholding statement;
- (b) Pay stubs;
- (c) An income tax return from the most recently filed calendar year;
- (d) Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
- (e) Forms approving or denying unemployment compensation; or
- (f) Written statements from employers or welfare agencies.

(3) In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital personnel are able to establish the position of the income level within the broad criteria described in WAC 246-453-040 or within income ranges included in the hospital's sliding fee schedule, the hospital is not obligated to establish the exact income level or to request the aforementioned documentation from the responsible party, unless the responsible party requests further review.

(4) In the event that the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

(5) Information requests, from the hospital to the responsible party, for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship, and may not be used to discourage applications for such sponsorship. Only those facts relevant to eligibility may be verified, and duplicate forms of verification shall not be demanded.

[Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-030, filed 2/14/91, effective 3/17/91.]

WAC 246-453-040 Uniform criteria for the identification of indigent persons. For the purpose of identifying indigent persons, all hospitals shall use the following criteria:

(1) All responsible parties with family income equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship;

(2) All responsible parties with family income between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with the

hospital's sliding fee schedule and policies regarding individual financial circumstances;

(3) Hospitals may classify any individual responsible party whose income exceeds two hundred percent of the federal poverty standard, adjusted for family size, as an indigent person eligible for a discount from charges based upon that responsible party's individual financial circumstances.

[Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-040, filed 2/14/91, effective 3/17/91.]

WAC 246-453-050 Guidelines for the development of sliding fee schedules. All hospitals shall, within ninety days of the adoption of these rules, implement a sliding fee schedule for determination of discounts from billed charges for responsible parties meeting the criteria in WAC 246-453-040(2). These sliding fee schedules must be made available upon request.

(1) In developing these sliding fee schedules, hospitals shall consider the following guidelines:

(a) The sliding fee schedule shall consider the level of charges that are not covered by any public or private sponsorship in relation to or as a percentage of the responsible party's family income;

(b) The sliding fee schedule shall determine the maximum amount of charges for which the responsible party will be expected to provide payment, with flexibility for hospital management to hold the responsible party accountable for a lesser amount after taking into account the specific financial situation of the responsible party;

(c) The sliding fee schedule shall take into account the potential necessity for allowing the responsible party to satisfy the maximum amount of charges for which the responsible party will be expected to provide payment over a reasonable period of time, without interest or late fees; and

(d) Hospital policies and procedures regarding the sliding fee schedule shall specify the individual financial circumstances which may be considered by appropriate hospital personnel for purposes of adjusting the amount resulting from the application of the sliding fee schedule, such as:

(i) Extraordinary nondiscretionary expenses relative to the amount of the responsible party's medical care expenses;

(ii) The existence and availability of family assets, which may only be considered with regard to the applicability of the sliding fee schedule;

(iii) The responsible party's future income earning capacity, especially where his or her ability to work in the future may be limited as a result of illness; and

(iv) The responsible party's ability to make payments over an extended period of time.

(2) Examples of sliding fee schedules which address the guidelines in the previous subsection are:

(a). A person whose annual family income is between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall have his/her hospital charges that are not covered by public or private sponsorship limited to forty percent of the excess of that person's annual family income over one hundred percent of the federal poverty standard, adjusted for

family size. This responsibility may be adjusted by appropriate hospital personnel after taking into consideration the individual financial circumstances of the responsible party. The responsible party's financial obligation which remains after the application of this sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party.

(b) A person whose family income is between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall have his/her hospital charges that are not covered by public or private sponsorship reduced according to the schedule below. The resulting responsibility may be adjusted by appropriate hospital personnel after taking into consideration the individual financial circumstances of the responsible party. The responsible party's financial obligation which remains after the application of this sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party. The schedule is as follows:

<u>INCOME AS A PERCENTAGE OF FEDERAL POVERTY LEVEL</u>	<u>PERCENTAGE DISCOUNT</u>
One hundred one to one hundred thirty-three	Seventy-five percent
One hundred thirty-four to one hundred sixty-six	Fifty percent
One hundred sixty-seven to two hundred	Twenty-five percent

(3) The provisions of this section and RCW 70.170.060(5) shall not apply to the professional services of the hospital's medical staff, provided that the charges for such services are either submitted by the individual medical staff or are separately identified within the hospital's billing system.

[Statutory Authority: Chapters 43.070 [43.70] and 70.170 RCW. 94-12-089, § 246-453-050, filed 6/1/94, effective 7/2/94. Statutory Authority: RCW 70.170.060. 91-05-048 (Order 142), § 246-453-050, filed 2/14/91, effective 3/17/91.]

WAC 246-453-060 Denial of access to emergency care based upon ability to pay and transfer of patients with emergency medical conditions or active labor. (1) No hospital or its medical staff shall adopt or maintain admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is, or is likely to be, less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

(2) No hospital shall adopt or maintain practices or policies which would deny access to emergency care based on ability to pay. No hospital which maintains an emergency department shall transfer